Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C IL6008684 B. WING 11/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 135 SOUTH MORGAN STREET **RUSHVILLE NURSING & REHAB CTR** RUSHVILLE, IL 62681 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Facility Reported Investigation (FRI) to Incident of 10//23/2021/IL139816 \$9999. Final Observations S9999 Statement of Licensure Violations: 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Attachment A Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: __ COMPLETED C IL6008684 B. WING 11/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 135 SOUTH MORGAN STREET **RUSHVILLE NURSING & REHAB CTR** RUSHVILLE, IL 62681 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 These Requirements were not evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision to prevent an injury for one of three residents (R2) reviewed for supervision in a sample of three. This failure resulted in R1 sustaining a fracture of the greater tuberosity. Findings include: R1's Facility Incident Report form dated 10/23/2021 documented the following under a section titled description of occurrence: "R1 sustained a fall on 10/22/2021, R1 was standing up receiving medication. R1 was standing in dining room and did not see other resident in wheelchair in hallway and was bumped causing R1 to lose balance and fall to the floor, R1 did not have her walker in front of her using it for stability." R1's Nursing Progress notes dated 10/22/2021 at 6:40 PM documents the following: "Writer (V3. LPN, Licensed Practical Nurse) was standing with (R1) in the dining room giving her medication and reminding her she needs to use her walker, she had her walker but not in front of her at the time. was at her table from eating supper. While writer (V3), was discussing this with resident, another resident (R2) was coming through the dining room in her wheelchair backwards and hit writer (V3), and (R1). (V3) reached for resident and both writer and resident fell to the floor. R1 landed on right side with back against the doors to the dining room. R1 denies pain except to left upper arm. Skin tear to left back of hand. Area

cleansed and dressing placed to left hand skin

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		T(X3) DAT	E SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		3:		PLETED
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
RUSHVILLE NURSING & REHAB CTR 135 SOUTH MORGAN STREET					
RUSHVILLE, IL 62681					
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with a start date of Behavioral Symptohistory of pushing I wheelchair, she run not seeing where s frustrated when as same care plan dohas difficulty makin to) CVA (cerebral vaphasia." R2's progress notedocument the followand able to make r some words. Resid likes to go backwar watch and to turn a construction of the following: On 10 at dinner and V3, L was giving R1 her r standing up, had he directly in front of hand bumped in to F LPN down. On 11/7/2021 at 9:2 Practical nurse) statime, around 5 or 6 medications to R1 i room. V3, LPN stated, R2 her wheelchair. V3	plan documents the following 9/2/2021: "Category: oms, Problem: (R2) has a herself backwards in her ins into other residents due to the is going and becomes king her not to do that." This cuments the following: (R2) og self-understood R/T (related rescular accident) with as dated 10/22/2021 at 1:20 pm wing: "Resident (R2) is alert needs known with gestures and tent propels her wheelchair, rds and has to be reminded to be r	S9999			

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